

Hidalgo #293, 45900, Chapala, Jalisco.

Phone numbers:

Telephone: (376) 765-7777

Cel: (331) 605-9645

U.S.: (312) 912-9087

PATIENT INFORMATION

Date: _____ Primary Care Provider: _____

Patient Name: _____ DOB: _____ Age: _____

Address: _____ City, State, Zip: _____

Home Phone#: _____ Mobile#: _____ Work#: _____

Social Security#: _____ Gender: _____ M _____ F

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

Type of Insurance: _____ Private _____ Worker's Comp _____ Auto _____ Personal _____ None

EMPLOYER INFORMATION

Occupation: _____

Employer: _____ Phone#: _____

Address: _____ City, State, Zip: _____

HEALTHCARE and MEDICAL WISHES

Emergency Contact(s) Name: _____ Relationship: _____

Tel: _____ Tel2: _____

DO YOU HAVE A LIVING WILL? _____ Do you have a Health care power of attorney? _____

Name of Insurance Company: _____ Policy#: _____

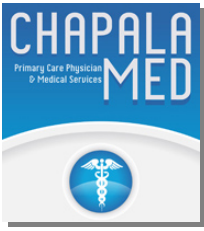
If you answered yes to any of these questions, whom? _____

Who knows your healthcare and END OF LIFE wishes best? _____

Who can or who do you wish to make Medical or END OF LIFE decisions for you if you are incapacitated or an emergency situation? _____

Name and contact information of the mentioned person(s): NAME(s) /Relationship: _____

Tel: _____ Address: _____



Hidalgo #293, 45900, Chapala, Jalisco.

Phone numbers:

Telephone: (376) 765-7777

Cel: (331) 605-9645

U.S.: (312) 912-9087

Por este documento _____

prometo pagar a la orden de **CHAPALA MED PRECISAMENTE EN LA CIUDAD DE CHAPALA, JALISCO** LA SUMA PRINCIPAL \$_____ (

) MONEDA DE CURSO LEGAL EN LOS

ESTADOS UNIDOS MEXICANOS EL DÍA ____ DE _____ DEL _____.

En caso de que el suscriptor no pague en la fecha de su vencimiento la totalidad del importe que deba pagar a **CHAPALA MED** conforme a este PAGARE, el suscriptor pagará, a la vista, intereses moratorios, a razón del cinco por ciento (5%) mensual, calculados desde el día de dicho vencimiento hasta e inclusive la fecha de su pago total.

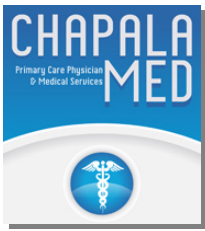
La suma principal de este PAGARE y los intereses correspondientes al mismo se le pagarán a **CHAPALA MED** en el domicilio ubicado en calle Hidalgo No. 293, C. P. 45900, en la ciudad de Chapala, Jalisco.

Para todo lo relativo a la interpretación y cumplimiento de este PAGARE, el suscriptor señala y se somete expresamente a la jurisdicción y competencia de los Juzgados y Tribunales del Primer Partido Judicial en la Ciudad de Chapala, Jalisco, renunciando clara y terminantemente a cualquier otro fuero que pudiese corresponderle por razón de su domicilio presente o futuro.

El presente PAGARE consta de una página y se suscribe en la ciudad de Chapala, Jalisco, ____ DE _____ DEL _____.

SUSCRIPTOR

Este PAGARE será utilizado solamente en casos de urgencias, tratamientos y procedimientos complejos u hospitalizaciones.



Hidalgo #293, 45900, Chapala, Jalisco.

Phone numbers:

Telephone: (376) 765-7777

Cel: (331) 605-9645

U.S.: (312) 912-9087

AVISO DE PRIVACIDAD

QUIÉNES SOMOS

Chapala Med **es responsable del tratamiento de sus datos personales, con domicilio en Hidalgo #293, C. P. 45900, Chapala, Jalisco.**

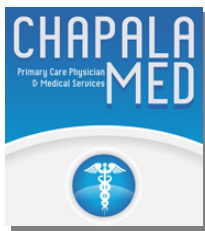
PARA QUÉ RECABAMOS Y UTILIZAMOS SUS DATOS

- **Prestación de servicios médicos** (cirugía., estudios diagnósticos, atención de enfermería, tratamientos oncológicos, análisis de laboratorio, radiología e imagen, estudios y análisis patológicos, terapia, rehabilitación, dieta y nutrición y demás fines relacionados con servicios de salud.)
- Creación, estudio, análisis, actualización y conservación del **expediente clínico.**
- **Facturación y cobranza por servicios.**
- **Estudios clínicos, registros, estadísticas y análisis de información de salud.**
- Conservación de **registros para seguimiento a servicios**, prestación de servicios en el futuro y en general para dar seguimiento a cualquier relación contractual
- Análisis estadísticos y de mercado.
- **Promoción y mercadeo** de productos y servicios de **Chapala Med** u otras empresas pertenecientes al mismo grupo corporativo

MÁS INFORMACIÓN

Si requiere mayor información puede acceder a nuestro aviso de privacidad completo a través de nuestra página web: www.chapalamed.com

NOMBRE Y FIRMA



Hidalgo #293, 45900, Chapala, Jalisco.

Phone numbers:

Telephone: (376) 765-7777

Cel: (331) 605-9645

U.S.: (312) 912-9087

WORK INJURY / PERSONAL INJURY / AUTO INJURY

Insurance Type: _____WORK INJURY _____AUTO _____PRIVATE

Date of Injury: _____ Claim#: _____

Name of Carrier: _____ Telephone#: _____

Address: _____ City, State, Zip: _____

Compensable Body Part: _____

Adjuster's Name: _____ Telephone#: _____

ASSIGNMENT AND RELEASE OF BENEFITS

Please understand that we can't, as a third party, become involved in prolonged insurance negotiations. This is your patient responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I authorize the physician to release any medical information including diagnosis, Xrays, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: Insurance, Diagnostic, Legal, and at times when the physician deems it necessary in order to ensure the best medical care on my behalf.

I further understand that any person(s) that receive these records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for the release of the information.

I CERTIFY that I have read and fully understand the above and accept financial responsibility in full for this account.

Signature of Patient

Date

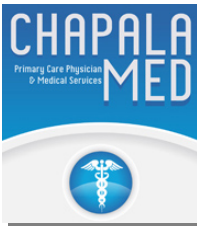
In case of emergency, please contact:

Name: _____

Address: _____

Phone Number: _____

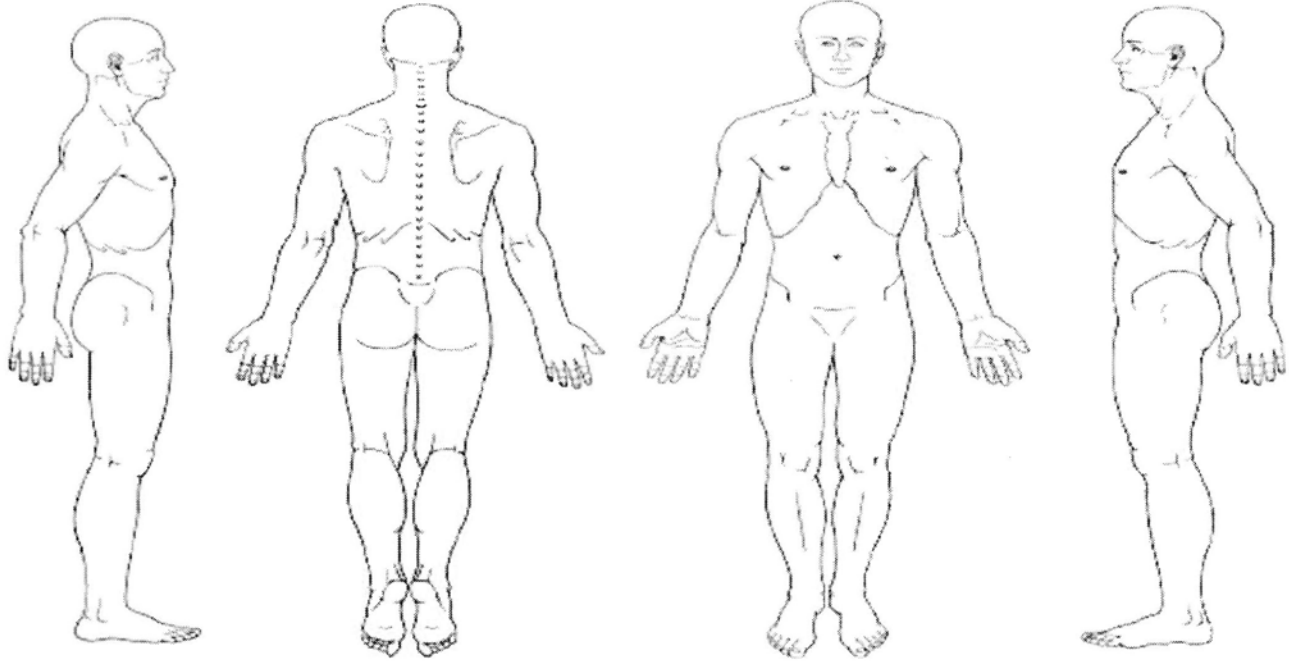
Relationship: _____



Hidalgo #293, 45900, Chapala, Jalisco.
 Phone numbers:
 Telephone: (376) 765-7777
 Cel: (331) 605-9645
 U.S.: (312) 912-9087

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN. ALSO MARK (X) FOR NUMBNESS, (T) FOR TINGLING, (B) FOR BURNING.



PAIN:

When did the pain begin?

HOW did it start?

- Work Accident Following surgery No Trauma Gradual onset
- Home accident Other accident or injury Auto accident Unknown

Duration of Pain

- 1-4 weeks 1-3 months 3-6 months Less than 1 yr. More than 1 yr. Many years

How often does the pain occur?

- Continuously Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day)
- Intermittently (0-25% of the day) Less than daily Weekly Monthly

Select one or more items below to describe the nature of your pain:

- Throbbing Shooting Sharp Cramping Hot/Burning Aching Stabbing Tingling Numbing Dull ache

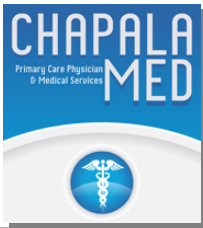
How do the following factors affect your pain?

Current Pain Score _____ (0-10, 10 being the Worst pain)

Best Pain Score _____

Worst Pain Score _____

	Worse	Better	No effect
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Hidalgo #293, 45900, Chapala, Jalisco.

Phone numbers:

Telephone: (376) 765-7777

Cel: (331) 605-9645

U.S.: (312) 912-9087

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Check the treatments you have had for pain:

- Acupuncture Physical Therapy Biofeedback Trigger Points Massage Hypnosis
- Exercise Psychotherapy TENS unit Chiropractor Brace Surgery
- Facet Blocks Epidurals Nerve Blocks Other

Imaging Studies/Tests Done:

- MRI CT Scan X-rays EMG/NCV Results of TEST _____

PAST MEDICAL HISTORY (circle all that apply)

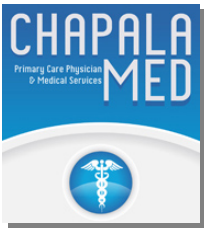
- Constitutional
- Obesity Weight loss Weight gain
- Musculoskeletal
- Arthritis Fibromyalgia Muscle spasms
- Neurological
- Headache Seizures Migraines
- Stroke
- Psychiatric
- Depression Substance Abuse Anxiety
- Anxiety Bipolar Schizophrenia
- Cardiovascular
- Angina Heart Attack Heart Stent
- Pacemaker High Blood Pressure (Hypertension)
- Respiratory
- Asthma Emphysema Chronic Bronchitis
- Lung Cancer
- Gastrointestinal
- Reflux Hepatitis Ulcers
- Irritable Bowel Syndrome Heartburn
- Cirrhosis Diverticulitis Colon Cancer
- Genitourinary
- Impotence Kidney Stones Incontinence
- Endocrine, Hematologic, Allergy/Immunologic, HEENT
- Diabetes Hypothyroidism Hyperthyroidism
- HIV Hyperlipidemia (Elevated Cholesterol)
- Leukemia Lymphoma Multiple Myeloma
- Rheumatologic
- Lupus Sjogren's Scleroderma
- Polymyalgia Rheumatica Rheumatoid Arthritis

REVIEW OF SYSTEMS (circle all that apply)

- Chills Fever Fatigue
- Numbness Weakness
- Confusion Dizziness Light Sensitivity
- Loss of consciousness
- Suicidal thoughts
- Difficulty Sleeping
- Chest Pain Palpitations
- Cough Shortness of Breath
- Diarrhea Constipation Abdominal Pain
- Bloating Nausea
- Vomiting
- Decreased Libido Urinary frequency
- Easy Bruising Ringing in Ears

Surgical History:

- Appendectomy _____ Tonsillectomy/Adenoids _____ Gallbladder surgery _____ Coronary Bypass _____
- Hernia Repair _____ Tubal Ligation _____ Mastectomy _____ Hysterectomy _____ Breast Biopsy _____
- Prostate _____ Vasectomy _____ Knee Replacement _____ Hip Replacement _____ Knee Surgery _____
- Shoulder Surgery _____ Cataracts _____ Colon _____ Liver Surgery _____
- Back Surgery: _____
- Neck Surgery: _____
- Other: _____



Hidalgo #293, 45900, Chapala, Jalisco.

Phone numbers:

Telephone: (376) 765-7777

Cel: (331) 605-9645

U.S.: (312) 912-9087

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

WOMEN: ARE YOU PREGNANT? YES NO NOT SURE PATIENT'S INITIALS _____

Social History:

Do you smoke? YES NO How many packs per day? _____ How many years? _____

Do you drink alcohol? YES NO How much per days? _____ How many years? _____

Do you use illicit drugs YES NO How much per days? _____ How many years? _____

FAMILY HISTORY:

CONDITIONS	DIABETES	HEART	ANXIETY	KIDNEY	CANCER	DEPRESSION	BACK	OTHER
MOTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FATHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BROTHER(S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SISTER(S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIES:

- Latex
- Iodine/ IV contrast
- Betadine
- Environmental

Drug ALLERGIES

1. _____
2. _____
3. _____

List All Medications You Are Currently Taking:

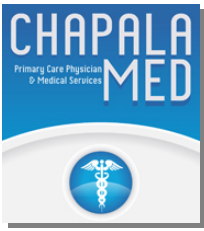
Medication	Dose	Medication	Dose
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

Past pain medications tried:

I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE



Hidalgo #293, 45900, Chapala, Jalisco.

Phone numbers:

Telephone: (376) 765-7777

Cel: (331) 605-9645

U.S.: (312) 912-9087

By signing this form, I _____, authorize the use and disclosure of my health information as described below:

1. You can disclose my health information as described below:

- leave messages on my answering machine
- leave messages with my spouse
- leave messages with anyone who answers phone

2. You can leave message confirming appointments as described below:

- leave messages on my answering machine
- leave messages with my spouse
- leave messages with anyone who answers phone

Name of person/persons authorized to receive this information: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except ⁽¹⁾ where uses or disclosures have already been made based upon my original permission or ⁽²⁾ the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or insurance policy. I understand that uses or disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to

Hidalgo #293 , 45900 Chapala, Jalisco, México.

Signature of Patient _____ Date _____

Print Name of Patient _____